DWS-UI
Form 661
Rev. 3/98

UTAH DEPARTMENT OF WORKFORCE SERVICES
Unemployment Insurance

MEDICAL REPORT

Name _____ SS # _____

To the Physician: The Utah Employment Security Act requires that an individual must be able to work to qualify for unemployment benefits. We request your opinion of this individual's physical ability to perform full-time work.

I hereby authorize release of medical information necessary to determine my eligibility for unemployment insurance benefits. I understand that any information provided on this form may be released to my former employer.

Claimant Signature _____ Date _____

1. Diagnosis (in lay terms) of this individual's illness, injury, or disability.

   _____

2. Date of first examination _____ More recent examination _____

3. During your treatment of the condition, did you advise the patient to:

   a. Take time off from work? ☐Yes ☐ No
   b. Change occupations? ☐Yes ☐ No
   c. Change employers? ☐Yes ☐ No
   d. Move to another area? ☐Yes ☐ No
   e. Discontinue working? ☐Yes ☐ No
   f. Other _____

   If answered "Yes," please give date patient was so advised _____

4. Was patient hospitalized? ☐Yes ☐ No If "Yes," give dates From _____ Through _____

5. How long was patient unable to perform full-time work? From _____ Through _____

6. If patient was advised to limit the kind, amount, conditions, or place of work because of his or her physical condition, please explain _____

   _____

7. If pregnant, give the expected date of chilfbirth _____

8. If after childbirth, give the date of childbirth _____

   a. Is the baby's condition adequate to be cared for by persons other than the mother? ☐Yes ☐ No

RETURN TO:

WORKFORCE SERVICES
CLAIMS CENTER
PO BOX 45266
SALT LAKE CITY UT 84145-0266
FAX (801) 526-4402

_____
Name of Physician (print or type) Telephone

_____
(Address)

_____
Signature of Physician Date